WEST COAST ENERGY CRISIS

The SPEAKER pro tempore (Mr. TIBERI). Under a previous order of the House, the gentleman from California (Mr. GEORGE MILLER) is recognized for 5 minutes.

Mr. GEORGE MILLER of California. Mr. Speaker, those of us living in California have reached a critical point in determining how Congress and the President will address the West Coast Energy Crisis.

Earlier today, the House Committee on Energy and Commerce canceled its consideration of a bill that would have prevented price-gouging and blackouts in California and other Western States. The President and the Federal Energy Regulatory Commission have said ''no'' time after time to Californians. Now it looks like the Republicans in Congress are saying ''no'' to California; also, ''we will not help you.''

This is very disturbing. The West Coast energy crisis threatens not only the health of our economy, but the health of our citizens, because the blackouts roll out through hospitals, through disabled individuals living in their own homes, in nursing homes and other facilities across our State. The President has said no. The Federal Energy Commission has said no, because they believe that price caps will not help the situation.

The President recently said in his visit to California that price caps would not help California, they would not increase supply or reduce demand. Yet we see that 10 of this Nation's leading economists wrote the President to politely disagree with him. They, in fact, made a very strong case. The cost-based price caps temporarily, until the energy supply can be reached in California, would, in fact, help stabilize, stabilize the supply of energy to California.

A majority of Americans recently expressed their opinions in the Washington Post, where 58 percent said they favored temporary price caps. Much of the energy crisis in California is beyond our own control, and certainly in the rest of the West. Because we are in the second driest year on record, we do not have the water behind the dams because of the drought to create hydroelectric power. The American people understand this, but the Republicans in Congress do not, the President of the United States does not, and the Federal Energy Regulatory Commission does not.

What is very disturbing is we watched the President develop an energy policy as we started to see the closeness between the administration, the White House and America's mainline energy companies. This past weekend we saw disclosed the strong personal financial ties of top members of the Bush administration's energy team to those very same energy generators. Many of us have been concerned about this for some time, but we now saw evidence of it.

Chief political strategist Karl Rove had a $100,000 to $250,000 investment in Enron, one of the major marketers of energy on the West Coast. Lawrence Lindsay gained $50,000 as a consulting fee from Enron. Condoleeza Rice, the National Security Advisor, $250,000 to $500,000 in Chevron and earned $60,000 as the director on the Chevron Board of Directors. Clay Johnson, director of the President's personnel, held stock valued between $100,000 and $250,000 in El Paso Energy Partners, a Houston oil and natural gas company, involved in the West Coast energy problems. The Washington Post also says that Mr. Johnson has been involved in selecting the people who will serve on the Federal Energy Commission, the very same people who will be regulating the companies in which he has a financial interest. Many of us were concerned that they were creating an office of special interest in the White House, and I think that concern is starting to come forward.

Mr. Speaker, one of the things that is kind of interesting is when we look at the President's energy policy and we look at the annual report of Exxon-Mobil, we find that many of the same consistencies are there. We see in the President's energy policy that he shows us that, in fact, they have energy for a new century, and here we have offshore oil drilling that is familiar to us; we have been doing it for many, many years. When we pick up the Exxon-Mobil annual report, we see the same dedication. This is not about energy for a new century, this is about an old fossil fuel-dependent economy from which America must move on.

Exxon wants to highlight its drilling techniques. We see the drilling techniques that show us that from one rig one can drill a number of different pockets of oil, one can do directional drilling, and one can reduce the supply. We go back to the President's energy policy, and we see that, in fact, we have essentially the same graphs, the same pictures, telling us that this is the way that we can get into the ANWR Wildlife Refuge, that if we drill it just the way that Exxon told us we could in their report, all things would be fine and there would be no environmental damage. Again, we see the closeness of the two. It goes on until we see the same points being made about refinery capacity, the same pictures, the same discussion.

The time has come for the administration to separate itself from a very old and tired energy policy, and to move on and engage the full ingenuity and the talent of the American economy and its creative energies and to move on to renewables, to move on to replaceable energy supplies so that America, in fact, can move on with its economy and its families will not have to continue to be gouged because of the greed of the same energy generators who are doing it on the West Coast of the United States.

SUGGESTIONS FOR IMPROVING THE ADMINISTRATION OF MEDICARE

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2001, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, since 1965, when Medicare was enacted, virtually all senior citizens and most people with disabilities have been able to access mainstream medical care. Each working day, Medicare beneficiaries make almost 1 million physician visits.

□ 1515

Medicare serves 39 million Americans, and deals with about 1 million health care providers: doctors, nurses, hospitals, nursing homes, and others.

Since 1974 when, as a medical student, I first started seeing patients, and for the next 20 years as a physician prior to coming to Congress, I saw firsthand how important Medicare was to my patients. Medicare has been a very important part of our Nation's health care system, and I want to preserve and protect it.

A couple of years ago, I served on the Bipartisan Medicare Commission: I resigned after I became concerned that my very active role in the bipartisan patient protection legislation would affect the chances of consensus being reached on the commission.

However, based on my past experience actually working with Medicare patients, after culling from my work on the commission, and after listening and learning from testimony before the Subcommittee on Health and the Environment, on which I sit, I have a few suggestions for improving Medicare's administration.

Mr. Speaker, these suggestions are not about sweeping Medicare reform. They do not deal with the long-term solvency of Medicare when the baby boomers retire. Those types of ''big picture'' decisions are beyond the scope of what my remarks are about today.

I make this observation: to ensure the long-term survival of Medicare, additional funding will be necessary. And, contrary to the intentions of others, ''Medicare reform'' will not pay for a prescription benefit and will not ensure the long-term solvency of the program without additional funds. The demographics and the costs of services and supplies are a factor we will have to deal with when we are talking about the baby boomers in Medicare.

I recently asked Secretary of Health and Human Services, Tommy Thompson, who was testifying before my committee, two questions: First, ''Do you think senior citizens are being overtreated in Medicare''; second, ''Do you think Medicare providers are overpaid?''

He replied that, with the caveat that we always need to be vigilant against abuse, it was not his experience as a Governor of Wisconsin that senior citizens in general were being overtreated,

or that providers were being paid too much.

I agree with him. It is certainly the case in Iowa, where our reimbursement rates rank right at the dead bottom of the Medicare rates. I believe that anyone who thinks that ''Medicare reform'' is going to save much money is going to have to consider either tighter price controls or further rationing of care or both.

Mr. Speaker, that does not mean that we in Congress should not consider a more rational way of structuring the program, or that we should not learn from other health care delivery systems, or that we cannot introduce or maintain choice in the system. It does not mean that dealing with Medicare's future cash short-falls is not important. It really is. It is one of the big entitlement programs we are going to have to deal with.

However, Mr. Speaker, in addition to the big picture concerns about Medicare, there are increasing concerns about Medicare's current complexity, the difficulties that both the beneficiaries and providers have in understanding its operations and the decision-making processes, and its failure to communicate to and to serve them effectively.

Until we deal with the big picture issues, the traditional fee-for-service public part of Medicare is going to be around for a long time, especially in the less urban areas.

So I think we need to address the ''little picture'' ways in which the Health Care Financing Administration, known as HCFA, implements Medicare policy. It would be easy to call HCFA a ''bureaucratic monster.'' Having dealt with HCFA from the perspective of a doctor, I appreciate the frustration in dealing with this agency that I hear from my fellow medical colleagues, from Iowa's hospital administrators and from other health care providers.

There are now over 110,000 pages of Medicare rules, policies, and regulations. In a recent AMA survey, more than one-third of the 653 responding physicians reported spending 1 hour completing Medicare forms and meeting administrative requirements for every 4 hours of patient care.

Physicians are now filling up volumes of charts for documentation, not for the patient, but for the government. The additional paperwork in patients' charts can actually impede or delay necessary care as the doctor sorts through voluminous paperwork trying to find the truly relevant information.

I am not here to bash the people who work in the agency, who by and large try to do their job. HCFA has been underfunded, and Congress has to share some blame for how poorly the system sometimes functions, because Congress frequently gives HCFA very complex and sometimes conflicting tasks, usually without necessary resources.

Furthermore, some of the problems are inherent in the way Medicare was set up to use the regional intermediaries. Some criticize HCFA's lack of national uniformity, but others criticize its lack of flexibility and its proscriptiveness. It is not easy drawing the right line between all of these concerns. Nevertheless, there are many ways that Medicare and HCFA function that not only lack common sense but, in my opinion, are blatantly unfair and unjust.

Take the case of Dr. Taylor, a Florida physician who received notice from Medicare requesting a refund of $66,960.01 for an alleged overpayment, to be paid within 30 days. So Dr. Taylor sent the refund to Medicare, and he requested a fair hearing.

It was more than 1 year before the hearing date. In the meantime, Medicare sent a letter to his patients stating that they had been overcharged and that a refund was due them from their doctor. Of course, that was pretty bad for that doctor's reputation, and it hurt his practice.

After his hearing 1 year later, it was determined all but $584.91 of the claims reviewed were accurate, and he was entitled to $66,357.10 back from the agency. But, it took another 15 months before he received the refund. No letter was sent to his patients explaining HCFA's mistake, and he was told by Medicare to forget about collecting any interest on his funds that were held by Medicare for 15 months.

Or take the case of a neurologist in good standing in New York who moved to Florida. He has not been able to get a Florida Medicare number for 4 months because of bureaucratic red tape. Since 60 to 70 percent of his patients are Medicare beneficiaries, he is running out of money to keep his practice going.

Or how about Dr. Wilson, an internist who gave influenza shots to patients? Bills were sent to the Medicare carrier and payment was sent for the shot, but not for the visit. The carrier was called and Dr. Wilson was told to use a number 59 modifier. The carrier agreed that the rule had not been advertised in Medicare publications, but that Dr. Wilson could buy a subscription to the information for $265. So now he has to pay HCFA to get the information he is supposed to have.

Dr. Wilson asked if he could resubmit the bill. The carrier said no. Dr. Wilson's office manager was subsequently told by a Medicare staffer that the carrier was in error. After a long time and a lot of hassle, he was finally properly reimbursed.

Or how about the cardiologist who went through prepayment review, i.e., an audit, for 793 claims. These claims were worth about $50,000. The cost to his practice of processing and producing documentation and reprocessing was $44,000. Eight denied claims, for which service was provided but for which the physician and his staff ultimately decided they did not have sufficient documentation, were ultimately worth $356.

Or consider this example. In March, 1999, an elderly man in heart failure was seen for 50 minutes by his doctor. The physician billed Medicare for a level 5 visit based on counseling services and the time required. The physician documented the time he spent with the patient. It was consistent with HCFA guidelines.

This service was denied by the carrier in February 2000. When the denial was appealed, the HCFA official held that the coding was based on time and was irrelevant, and thus, downcoded the service. This ruling was made despite a clear directive from national Medicare, from the Medicare carrier's manual, that the carrier should pay for counseling services when appropriately documented.

Thus, in this case the physician provided a medically necessary and appropriate service. He documented it correctly, and ultimately required 2 years and a hearing to be paid part of the appropriate fee. By the way, since the amount was for less than the $500 minimum required for appeal, the doctor had no administrative appeal rights.

These inconsistencies are not isolated instances. In Minnesota, for instance, there are 107 local medical review policies by the Medicare carrier. Just across the river in Wisconsin, there are 244 local medical review policies. Minnesota has nine policies for cardiovascular disease, Wisconsin has 27. I daresay that the heart care in Minnesota is just as good as the heart care in Wisconsin.

Years ago when I was in reconstructive surgery practice in Des Moines, Iowa, Medicare stopped giving prior authorization for certain types of reconstructive surgery. For example, some elderly patients have such droopy upper eyelids that they cannot see laterally. That is a hazard when they drive. They cannot see a car alongside them when they are on the freeway. I would point out that this hazard is not just to them, but to other drivers on the road as well.

What I would do is I would give a visual field examination; send the patient to an ophthalmologist, get a consultation. They do tests to see how much vision was lost. Then I would take some pictures. Then I would include all of that information in a letter to the HCFA carrier requesting prior authorization, just so that the patient would know that their surgery would be covered by Medicare and would not be considered ''cosmetic.''

However, a number of years ago, HCFA said, ''We are not doing prior authorizations anymore. Tell the patient we will look at the case afterwards and then decide whether we will pay for the service.''

□ 1530

Well, this haphazard policy scares a lot of elderly from getting the care that they need. If a carrier makes a decision to deny the claim after the fact as being noncovered, the provider has

no right to appeal and then he must bill the patient.

This is not just about surgery. Cancer, heart disease, hypertension, diabetes are common conditions in elderly Americans. Those conditions are often treated with medications. In all these conditions, the patient's status may remain stable, but it is important to regularly evaluate the patient's disease to make certain the medications are satisfactory. These services are part of the continuing care of patients, and they should not be subject to an arbitrary local decision concerning coverage.

Mr. Speaker, hospitals are in the same position with HCFA as physicians: overwhelming paperwork, confusing rules, punitive penalties for honest mistakes. Some rural hospitals have almost as many billing clerks as they do beds. Memorial Hospital in Gonzales, Texas has 33 beds, and it has a billing staff of 20 employees.

Northwestern Memorial Hospital in Chicago spends more than 3,200 staff hours per month sorting through Medicare billing requirements alone. This year alone, Northwestern Memorial Hospital is adding 26 new employees solely to ensure compliance with regulations.

Direct care is affected, too. A cardiologist recounts how when he made rounds one day on one of the hospital floors, two nurses were taking care of patients and the other six nurses were checking documentation to make sure it complied with Medicare regulations.

A critical care physician whose practice staffs a local hospital 24 hours a day and who actually advises the carrier on coding issues is now going through a post-payment audit. In years past, the carrier has cited that physician as providing laudable care. However, the carrier has denied the physician's nighttime critical care claims.

Now, since his practice staffs the hospital 24 hours a day, 7 days a week, I would suggest that it is absurd to suggest that patients do not require care in the middle of the night. In fact, this 24-hour-a-day service resulted in reducing mortality rates in that hospital.

Secretary Thompson, in his confirmation hearing said, ''Patients and providers alike are fed up with excessive and complex paperwork. Complexity is overloading the system, criminalizing honest mistakes and driving doctors, nurses and other health professionals out of the program.'' I agree.

So what can Congress do? Well, the following is a list of about 25 suggestions that I have. It is not comprehensive. Some are specific; some are general. Many of these are garnered from testimony before my committee. But I think if we would implement these, it would go a long way towards helping the Health Care Financing Administration work better. I will try not to get too technical.

First, the Medicare Regulation and Regulatory Fairness Act of 2001, known on Capitol Hill as MRRFA, H.R. 868, introduced by the gentleman from Pennsylvania (Mr. TOOMEY) and the gentlewoman from Nevada (Ms. BERKLEY) would require HCFA contractors to educate physicians and providers as to coding, documentation and billing requirements so that fewer billing errors ultimately occur.

The approach by HCFA should be education rather than heavy-handed audits. MRRFA would also provide health care providers with greatly needed due process rights in those post payment audits.

Number two, last August, the previous administration issued regulations that would require physician practices to treat Medicaid patients and other program beneficiaries to include, at their own expense, the cost of hiring trained clinical interpretors to assist those patients who have limited English proficiency.

Mr. Speaker, I was in practice for quite a while. There are a lot of immigrants in Des Moines, Iowa: Hispanic, African, Bosnian. Many would come to my office without being proficient in English, so we would make arrangements to have a translator. It would be a member of the family. It would be a friend who spoke English. It would be a person who works with a nonprofit agency or a religious institution that was helping those immigrants get settled. We could work it out. This regulation needs to be looked at.

Number three, we need to look at the Emergency Medical Treatment and Labor Act, or EMTALA. HCFA has been attempting to expand the scope of this bill to reach well beyond hospital emergency departments to encompass nonemergency inpatient facilities and hospital outpatient department care.

We need to seriously consider the effect of those regulations, and we need to look at the EMTALA law itself. We need to and see how well it is working and the implications that it has had in terms of our oversight and the ability for emergency rooms to staff the type of specialty care that they need.

Number four, Congress should require the Secretary of Health and Human Services to publish in the Federal Register, no less than a quarterly basis, a notice of availability for all proposed policy and operational changes which can affect providers and suppliers. This would include, but not be limited to, changes issued through amendments in the carrier manuals.

The Secretary should require contractors to notify all providers and suppliers in their service area of such changes within 30 days of the Federal registered notice. The Secretary should further provide that any changes issued in the final form should take effect no earlier than 45 days from the date of such final change in the Federal Register.

Number five, Congress should require the Secretary of Health and Human Services to create and distribute a user-friendly manual that contains all the information necessary for medical Medicare compliance. The manual should be organized and accessible. It should be on-line. It should be free. One should not have to pay $265 for a Medicare manual when it is required to follow the rules. It should contain, in addition to actual regulations, a summary of each issue, including questions and answers.

Number six, Congress should require the Secretary of Health and Human Services to develop a site on the Internet, something that people can access, where Medicare providers and suppliers can post questions and obtain feedback to understand what those regulations are.

Number seven, Congress should require the Secretary of Health and Human Services to furnish all education and training materials and other resources and services free of charge to providers, eliminating user fees. This Congress, for many, many years, opposed the user fees that the Clinton administration wanted to impose on a wide variety of areas. This should be no different.

Number eight, Congress should instruct Health and Human Services to provide better oversight of its contractors to ensure a more uniform application of national policies and a more efficient administration of the Medicare program.

Number nine, this cuts across a lot of providers, we need to look at and fix some of the costly and needlessly burdensome HPPA medical privacy regulations. I am encouraged by Secretary Thompson's decision to re-open the privacy rule for comments and urge him to spend the effective date and fix the rule. I believe a better privacy rule would benefit patients and providers alike. Many provisions in the time rule and the aggressive implementation schedule were written without consideration of the impact on patient care.

Number 10, emergency services needed to stabilize patients should not be denied payment. Participating providers in the Medicare program are required to screen any individual who comes to the emergency department to determine whether that person has an emergency medical condition or is a woman in active labor, and if so, to stabilize him or her. To adequately screen and stabilize a patient, hospitals often employ ancillary services that are routinely available to the emergency department. Medicare sometimes denies payment for the services furnished in the emergency department because they exceed the ''local medical review policies or utilization guidelines for coverage.'' We need to look at that.

Number 11, we need to limit data collection to what is necessary for payment and for quality. Prospective payment systems should be simple, predictable and fair. Unfortunately, the patient assessment tools for skilled nursing, rehabilitation and home health are far from ideal. In fact, HCFA has devised three separate instruments, the outcome and assessment information set, the minimum

data set, and the MDSPAC, which collects a lot of extraneous information. They lack statistical reliability and are extremely burdensome to many providers. We need to look at that.

Number 12, we need to provide adequate and stable funding levels to the HCFA carriers. We need to assure adequate funding levels so that the contractors can perform the range of functions necessary for an efficient operation of the Medicare program.

If I, as a physician in Des Moines, Iowa, have to deal with my local Medicare carrier, and they only are provided enough funds for a couple of employees, then I am going to have long waits, and my patient are too. This is something that Congress needs to look at.

Number 13, we need to avoid counterproductive reforms. We need to look at the way that we award contracts for the carriers. I am concerned about fragmenting and weakening the Medicare administration. This has broader implications as well. Some people are proposing that we break apart certain functions from Medicare. I would be very careful of that, particularly on the bigger issue of prescription drugs.

Number 14, we need to direct HCFA to utilize a consistent standard for the calculation and application of the ''low cost or charges'' rule during the transition from cost reimbursement to the prospective payment system for home health care.

Number 15, we need to eliminate the inappropriate demands for documentation to support reimbursement claims by requiring fiscal intermediaries to adhere to professional auditing standards and generally acceptable account practices. That should be a no-brainer.

Number 16, we need to restrict HCFA's ability to demand financial records from commonly owned or controlled organizations that do not have financial transactions with a Medicare home health agency. It is not their business.

Mr. Speaker, some of these will be a little bit more generic, and some of these are suggestions that were made before my committee by Bruce Vladick. Dr. Bruce Vladick, is the recent administrator for the Health Care Financing Administration. Mr. Vladick and I served together for a while on the Medicare Commission. I respect his opinions a lot. Many of these suggestions are ones that he has made to Congress.

Number 17, despite significant improvements through the Medicare handbook, the beneficiary hotline and Medicare Internet site and the program of the size of Medicare, the beneficiaries need, not just the providers, they need better customer service.

□ 1545

So we should improve the customer service by ensuring that each beneficiary has access to an individual to assist with Medicare problems. We should contract for at least one Medicare representative for every Social Security office in the country. That is like an ombudsman.

Number 18: We should reduce uncertainty and unplanned spending by requiring carriers to provide beneficiaries and providers advance guidance on certain procedures and services. This gets directly to what I was talking about earlier on the issue of prior authorization.

Number 19: Beneficiaries are subjected to too much and confusing paperwork, particularly if they have Medigap coverage. So a solution would be to reduce paperwork by requiring Medicare and Medigap health insurance carriers to transfer information and claims to one another electronically.

Number 20: This is really important. A lot of providers for Medicare are operating in an atmosphere of distrust and fear because of accelerated fraud and abuse activities. Make no mistake, we need to be firm and strong on preventing fraud and abuse. However, at the same time, we need to be fair; and we should not be counterproductive. And so to increase the comity and the provider confidence in the Medicare program, we should eliminate, in my opinion, the application of the False Claims Act to bills submitted by providers. We are talking about, in some of these situations, the mere slip of a finger, where one number could be recorded wrong on a form and then that physician could be held criminally at risk. That needs to be looked at.

Number 21: Many providers cannot obtain assistance with their Medicare questions. So to fix that we should improve customer service by assigning each provider an account executive and increasing the number of contractor and HCFA staff to interact with the provider. We should provide the patient an ombudsman, and we ought to provide the providers a similar service.

Number 22: The paperwork requirements for physicians, particularly surrounding the documentation of evaluation and management activities, is very, very onerous. I hear this from my colleagues all around the country. Oh boy, you ought to read the volumes to try to figure out how you code and then bill for an office visit. We should reduce paperwork by replacing those EMM codes with a simpler classification system. There are a number of ways we could look at doing that.

Number 23: HCFA's response to issues and problems is slowed considerably because of the multiple layers of bureaucracy in the Department of Health and Human Services and competing constituencies. So in order to improve responsiveness and timeliness, we should, I think, at least consider establishing HCFA as an independent agency. I am not, however, in favor of splitting functions away from HCFA.

Number 24: I have mentioned this before in this talk, but Medicare operations are severely underfunded. It reduces the efficiency, timeliness and customer service. To improve customer service and efficiency we should fund HCFA operations from a trust fund similar to that of the Social Security Trust Fund.

Number 25: With new life-enhancing technologies, the Medicare process to determine whether a new item or service will be covered is slow, confusing, and very contentious. We had testimony before Congress from Art Linkletter. He said it is just a shame that it can take up to 5 years to get an authorization for a new treatment or a new medical technology, and I agree. And we ought to assure availability of up-to-date but effective technologies by looking at an independent advisory board.

Number 26: The efficient organization, performance, and oversight of Medicare fiscal intermediaries and carriers is hampered by legislative prohibitions against competition and financial incentives for good performance. We should improve contractor performance by modernizing the legislative authorities, including the authority to compete for contracts and to financially reward good performance.

Well, Mr. Speaker, that is a lot of detail, but my committee, the Subcommittee on Health of the Committee on Energy and Commerce, is working on HCFA reform bill now. We are putting together a bill on this.

I want to finish this special order with a quote from Dr. Bruce Vladeck, former director of the Health Care Financing Administration. Mr. Vladeck said this. ''While debate about the future shape of the Medicare program rages on around us, tens of millions of beneficiaries and providers are interacting with Medicare on a daily basis, often in a suboptimal manner. As these big picture discussions continue, taking incremental steps to improve those interactions can significantly improve the lives of Medicare patients and the persons and institutions who serve them. Our citizens deserve nothing less.''

NATION'S ENERGY CRISIS

The SPEAKER pro tempore (Mr. TIBERI). Under the Speaker's announced policy of January 3, 2001, the gentleman from California (Mr. FILNER) is recognized for 60 minutes as the designee of the minority leader.

Mr. FILNER. Mr. Speaker, we intend to spend the next hour of the House's time in discussing the electricity and energy crises that are confronting this Nation today. This has become the issue that is paramount in the minds of families all over this Nation. Whether they live in California, which as in many other areas has pioneered the problem, where we have an economy that is teetering as the prices of natural gas and electricity and gasoline hit us, hit our families, hit our businesses, people see this crisis spreading to the other parts of the far West, in the mountain States and now to the East.